STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155799	A. BUILDING _____ B. WING _____	R 03/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION REHABILITATION AND ASSISTED LIVING CENTER	**614 WEST 14TH STREET MARION, IN 46953**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to the Annual Recertification and State Licensure Survey completed on January 12, 2015. This visit was in conjunction with the PSR to the Investigation of Complaint IN00160710 completed on December 11, 2014 and the Investigation of Complaints IN00166372 and IN00165872. Survey date: February 25, 26, 27 March 2 and 3, 2015. Facility number: 012809 Provider number: 155799 AIM number: 201136580 Survey Team: Angela Selleck, RN, TC Angela Strauss, RN Sue Brooker, RD (February 27, March 2 and 3, 2015) Census bed type: SNF: 40 SNF/NF: 16 Residential: 33 Total: 89 Census payor type: Medicare: 26 Medicaid: 16 Other: 47 Total: 89 Residential Sample: 1	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155799	A. BUILDING _____ B. WING _____	R 03/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION REHABILITATION AND ASSISTED LIVING CENTER	**614 WEST 14TH STREET MARION, IN 46953**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	Continued From page 1 Marion Rehabilitation and Assisted Living Center was found to be in compliance with 410 IAC 16.2-3.1 in regard to the PSR to the Recertification and State Licensure Survey. Quality review completed on March 4, 2015 by Randy Fry RN.	{F 000}		